advanced
EAR, NOSE & THROAT
head and neck surgery

Randall S. Lomax D.O.

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, M.I.)				SSN
HOME TELEPHONE	MOBILE TELEPHONE	AGE	DOB	SEX
PATIENT ADDRESS			APT/SPACE/UNIT#	
CITY	STATE	ZIP CODE	EMAIL ADDRESS	
NOTIFY IN CASE OF EMERGENCY	TELEPHONE		RELATIONSHIP	
EMERGENCY ADDRESS		CITY	STATE	ZIP CODE

RESPONSIBLE PARTY

GUARANTOR NAME (LAST, FIRST, M.I.)		SEX	DOB	SSN
GUARANTOR ADDRESS		TELEPHONE		
CITY		STATE		ZIP CODE
REASON FOR VISIT	REFERRING PHYSICIAN		HOW DID YOU HEAR ABOUT OUR OFFICE?	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY			TELEPHONE	
POLICY HOLDER'S DOB	POLICY HOLDER'S SSN	POLICY NUMBER	EFFECTIVE DATE	GROUP NUMBER
SECONDARY INSURANCE COMPANY			TELEPHONE	
POLICY HOLDER'S DOB	POLICY HOLDER'S SSN	POLICY NUMBER	EFFECTIVE DATE	GROUP NUMBER

PHARMACY INFORMATION

PREFERRED PHARMACY	PHONE NUMBER	ADDRESS/CROSS STREETS

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage. A copy of the signature is valid as the original. (A $25.00 fee will be charged if I do not call 24hrs prior to canceling my appointment.)

PATIENT/GUARDIAN SIGNATURE	DATE	GUARANTOR SIGNATURE

6850 N Durango Dr., Ste 314 • Las Vegas, NV 89149 • Ph: 702-834-5886 Fax: 702-834-5752